the calendar day after the date the beneficiary (or his or her representative) receives notification (either orally or in writing) of the expedited determination by the QIO.

(3) *Untimely filing.* When a beneficiary does not file a request for an expedited determination by the QIO in accordance with paragraph (d)(1) of this section, that beneficiary may be responsible for charges that extend beyond the date specified on the hospital's advance written notice of termination or as otherwise stated by the QIO.

(4) *Hospital requests expedited review.* When the hospital requests review in accordance with §405.1208, and the QIO concurs with the hospital's decision, a hospital may not charge a beneficiary until the date specified by the QIO.

(g) *Notice of an expedited determination.* (1) When a QIO issues an expedited determination in accordance with paragraph (e)(5) of this section, the QIO must notify the beneficiary, physician, and hospital of its decision, by telephone and subsequently in writing.

(2) A written notice of the expedited determination must contain the following:

(i) The basis for the determination;

(ii) A detailed rationale for the determination;.

(iii) A statement explaining the Medicare payment consequences of the expedited determination and date of liability, if any;

(iv) A statement informing the beneficiary of his or her subsequent appeal rights, and the timeframe for requesting a reconsideration by the QIC.

(h) *Effect of an expedited QIO determination.* The QIO determination is binding upon the beneficiary, physician, and hospital, except in the following circumstances:

(1) *When beneficiary remains in the hospital.* If the beneficiary is still an inpatient in the hospital and is dissatisfied with the determination, he or she may request a reconsideration according to the procedures described in §405.1204. If the beneficiary does not make a request in accordance with paragraph (d)(1) of this section, the timeframes described in §405.1204(c)(3), the escalation procedures described in §405.1204(c)(5), and the coverage rule described in §405.1204(f) will not apply.

(2) *When beneficiary is no longer an inpatient in the hospital.* If the beneficiary is no longer an inpatient in the hospital and is dissatisfied with this determination, the determination is subject to the general claims appeal process.

§ 405.1208 Hospital requests expedited QIO review.

(a) *General rule.* If the hospital (acting directly or through its utilization review committee) believes that the beneficiary does not require further inpatient hospital care but is unable to obtain the agreement of the physician, it may request an expedited determination by the QIO.

(b) *Procedures hospital must follow.* (1) The hospital must (acting directly or through its utilization review committee) notify the beneficiary (or his or her representative) that it has requested that review.

(2) The hospital must supply any pertinent information the QIO requires to conduct its review and must make it available by phone or in writing, by close of business of the first full working day immediately following the day the hospital submits the request for review.

(c) *Procedures the QIO must follow.* (1) The QIO must notify the hospital that it has received the request for review and must notify the hospital if it has not received all pertinent records.

(2) The QIO must examine the pertinent records pertaining to the services.

(3) The QIO must solicit the views of the beneficiary in question.

(4) The QIO must make a determination and notify the beneficiary, the hospital, and physician within 2 working days of the hospital's request and receipt of any pertinent information submitted by the hospital.

(d) *Notice of an expedited determination.* (1) When a QIO issues an expedited determination as stated in paragraph (c)(4) of this section, it must notify the beneficiary, physician, and hospital of its decision, by telephone and subsequently in writing.

(2) A written notice of the expedited initial determination must contain the following:

(i) The basis for the determination;.

(ii) A detailed rationale for the determination;

(iii) A statement explaining the Medicare payment consequences of the expedited determination and date of liability, if any; and

(iv) A statement informing the beneficiary of his or her appeal rights and the timeframe for requesting an appeal.

(e) *Effect of an expedited determination.* The expedited determination under this section is binding upon the beneficiary, physician, and hospital, except in the following circumstances:

(1) *When a beneficiary remains in the hospital.* If the beneficiary is still an inpatient in the hospital and is dissatisfied with this determination, he or she may request a reconsideration according to the procedures described in §405.1204. The procedures described in §405.1204 will apply to reconsiderations requested under this section. If the beneficiary does not make a request in accordance with paragraph (d)(1) of this section, the timeframes described in §405.1204(c)(3), the escalation procedures described in §405.1204(c)(5), and the coverage rule described in §405.1204(f) will not apply.

(2) *When a beneficiary is no longer an inpatient in the hospital.* If the beneficiary is no longer an inpatient in the hospital and is dissatisfied with this determination, this determination is subject to the general claims appeal process.

Subparts K–Q [Reserved]

Subpart R—Provider Reimbursement Determinations and Appeals

AUTHORITY: Secs. 205, 1102, 1814(b), 1815(a), 1833, 1861(v), 1871, 1872, 1878, and 1886 of the Social Security Act (42 U.S.C. 405, 1302, 1395f(b), 1395g(a), 1395l, 1395x(v), 1395hh, 1395ii, 1395oo, and 1395ww).

SOURCE: 39 FR 34515, Sept. 26, 1974, unless otherwise noted. Redesignated at 42 FR 52826, Sept. 30, 1977.

§405.1801 Introduction.

(a) *Definitions.* As used in this subpart:

Administrator means the Administrator or Deputy Administrator of CMS.

Administrator's review means that review provided for in section 1878(f) of the Act (42 U.S.C. 1395oo(f)) and §405.1875.

Board means the Provider Reimbursement Review Board established in accordance with section 1878 of the Act (42 U.S.C. 1395oo) and §405.1845.

Board hearing means that hearing provided for in section 1878(a) of the Act (42 U.S.C. 1395oo(a)), and §405.1835.

Date of filing and *date of submission of materials* mean the day of the mailing (as evidenced by the postmark) or hand-delivery of materials, unless otherwise defined in this subpart.

Date of receipt means the date on the return receipt of ''return receipt requested'' mail, unless otherwise defined in this subpart.

Intermediary determination means the following:

(1) With respect to a provider of services that has filed a cost report under §§413.20 and 413.24(f) of this chapter, the term means a determination of the amount of total reimbursement due the provider, pursuant to §405.1803 following the close of the provider's cost reporting period, for items and services furnished to beneficiaries for which reimbursement may be made on a reasonable cost basis under Medicare for the period covered by the cost report.

(2) With respect to a hospital that receives payments for inpatient hospital services under the prospective payment system (part 412 of this chapter), the term means a determination of the total amount of payment due the hospital, pursuant to §405.1803 following the close of the hospital's cost reporting period, under that system for the period covered by the determination.

(3) For purposes of appeal to the Provider Reimbursement Review Board, the term is synonymous with the phrases ''intermediary's final determination'' and ''final determination of the Secretary'', as those phrases are used in section 1878(a) of the Act.

(4) For purposes of §405.376 concerning claims collection activities, the term does not include an action by CMS with respect to a compromise of a Medicare overpayment claim, or termination or suspension of collection action on an overpayment claim, against